CDC Diphtheria Worksheet

PATIENT INFORMATION

Date of Request (Month / Day / Year)

Name (Last, First)

Birth Date (Month / Day / Year)

Age (Unk = 999)

Age Type
0 = 0-120 years
1 = 0-11 months
2 = 0-52 weeks
3 = 0-28 days
9 = Age unknown

Sex
M = Male
F = Female
U = Unknown

Pregnant?
Y = Yes
N = No
U = Unknown

Race
N = Native Amer./Alaskan Native
A = Asian/Pacific Islander
B = African American
W = White
O = Other
U = Unknown

Ethnicity
H = Hispanic
N = Not Hispanic
U = Unknown

Address (Street and No.)

County

State

Zip

Phone

Date Symptom Onset (Month / Day / Year)

Date First Diagnosis (Month / Day / Year)

Date Hospitalized (Month / Day / Year)

History of Immunization Against Diphtheria

Childhood Primary Series?
Y = Yes
N = No
U = Unknown

If < 18 Years Old, Number of Doses

Boosters as Adult?
Y = Yes
N = No
U = Unknown

Date of Last Dose (Month / Day / Year) OR U = Unk

Description of Clinical Picture

Outcome
N = Recovered, No Residua
R = Recovered, Residua
D = Died
U = Unknown

CLINICAL INFORMATION

Enter Y = Yes, N = No, or U = Unknown in the Boxes Below Unless Otherwise Indicated

Symptoms

- Fever?
- Sore Throat?
- Difficulty Swallowing?
- Change in Voice?
- Shortness of Breath?
- Weakness?
- Fatigue?
- Other?

Signs

- Fever?
- If Yes, Temp ___.___ °C
- Membrane?
- If Yes, Site(s)
  - Tonsils
  - Soft Palate
  - Hard Palate
  - Larynx
  - Nares
  - Nasopharynx
  - Conjunctiva
  - Skin
- Soft Tissue Swelling? (Around Membrane)
- Neck Edema?
- If Yes: B = Bilateral, L = Left Side Only, R = Right Side Only
- If Yes, Extent: S = Submandibular Only, M = Midway to Clavicle, C = To Clavicle, B = Below Clavicle
- Stridor?
- Wheezing?
- Palatal Weakness?
- Tachycardia?
- EKG Abnormalities?

Complications

- Complications?
- Airway Obstruction?
- Date of Onset (Month / Day / Year)
- Intubation Required?
- Myocarditis?
- Date of Onset (Month / Day / Year)
- (Poly)neuritis?
- Date of Onset (Month / Day / Year)
- Other?
- Describe:

LABORATORY

Specimen for Diphtheria Culture Obtained?
Y = Yes
N = No
U = Unknown

If Yes, Obtained on (Month / Day / Year) OR U = Unknown

Culture Result
P = Positive
N = Negative
U = Unknown

Specify Lab Performing Culture:

If Culture Positive, Biotype
M = Mitis
G = Gravis
I = Intermedious
B = Belfanti

If Culture Positive, Results of Toxigenicity Testing
X = Not Done
P = Positive
N = Negative
U = Unknown

Specimen Sent to CDC Diphtheria Lab for Confirmation/Molecular Typing?
Y = Yes
N = No
W = Will be Sent

Type of Specimen (Check All That Apply)
- Clinical Swab
- Piece of Membrane
- *C. diphtheria* Isolate

Serum Specimen for Diphtheria Antitoxin Antibodies Obtained?
Y = Yes
N = No
W = Will be Obtained Prior to DAT

PCR Result
P = Positive
N = Negative
U = Unknown
X = Not Done

ANTIBIOTICS

Treated with Antibiotics?
Y = Yes
N = No

As an Outpatient

If Yes, Date Initiated (Month / Day / Year)

Antibiotic (See Codes Below)

Duration of Therapy (Days)

Antibiotic Therapy in Hospital?
Y = Yes
N = No

As an Inpatient

If Yes, Date Initiated (Month / Day / Year)

Antibiotic (See Codes Below)

Duration of Therapy (Days)

Were Antibiotics Given in the 24 Hours Before Culture?
Y = Yes
N = No
U = Unknown

Antibiotic Codes

1 = Erythromycin (incl. Pediazole, ilosone)
2= Penicillin (Bicillin, Pfizerpen-AS, Wycillin)
3 = Amoxicillin/Ampicillin/Augmentin/Ceclor/Cefixime
4 = Tetracycline/Doxycycline
5 = Cotrimoxazole (bactrim/septra)
6 =
7 = Other
= Unknown

EXPOSURE

Country of Residence ☐ U = US O = Other

If Other, Country Name:

Date of US Arrival Month Day Year OR ☐ U = Unknown

History of International Travel? (2 Weeks Prior to Onset) ☐ Y = Yes N = No U = Unknown

Country(s) Visited | From Month Day Year | To Month Day Year

History of Interstate Travel? (2 Weeks Prior to Onset) ☐ Y = Yes N = No U = Unknown

State(s) Visited | From Month Day Year | To Month Day Year

Known Exposure to Diphtheria Case or Carrier? ☐ Y = Yes N = No U = Unknown

Known Exposure to International Travelers? ☐ Y = Yes N = No U = Unknown

Known Exposure to Immigrants? ☐ Y = Yes N = No U = Unknown

REPORTING INFORMATION

Has This Suspected Case Been Reported to The State or Local Health Department? ☐ Y = Yes N = No U = Unknown

Date Reported to State or Local Health Department Month Day Year

Person Informed: Phone - - Fax - -

Reporting Physician: Phone - - Fax - -

REQUESTING PHYSICIAN

Name

Institution

Street

City | **State** | **Zip**

Phone - - | **Fax** - -

Name of Investigator Under the IND (If Different From Requesting Physician) | **Phone** - - | **Fax** - -

SEND DRUG TO

Name

Attn.

Institution

Street

City | **State** | **Zip**

Phone - - | **Fax** - -

DOSE

Amount of DAT Administered: , IU DAT

DISPOSITION

Final Diagnosis:

How Was the Final Diagnosis Confirmed?

Final Case Disposition ☐ C = Confirmed P = Probable N = Not a Case